# Exhibit 5

# PLEASE DO NOT DETACH

Medical Licensing Examination

## STEP 1 AND/OR STEP 2 EXAMINATIONS

ATTACHMENT 2

ADMINISTERED TO STUDENTS/GRADUATES OF FOREIGN MEDICAL SCHOOLS BY
THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, 3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, USA
PHONE: 215 386-5900 CABLE: EDCOUNCIL,PHA

## PART A

*NOTE: All items on all sides of the application must be filled out completely for initial and repeat examinations or application will not be accepted. Use typewriter or block print in ink.*

**① ECFMG EXAMINATION HISTORY:**
Have you previously submitted an application to ECFMG to take one or more of the examinations administered by ECFMG? ☐ Yes ☑ No
If yes, place your USMLE Identification Number (ECFMG Applicant Number) in this box. 513-573-(illegible)

**② NAME:** Print your name as you want it to appear on the Standard ECFMG Certificate and on your official USMLE record
First Name: OLUWAFEMI
Middle Name: IGBERASE
Last Name (Surname): CHARLES
Full Maiden Name (For married women only):
482-7002

**2.1 If you have previously applied to ECFMG under another name, provide that name**
Previous Name: N/A
Please include a copy of the legal document that verifies this name change.

**③ ADDRESS:** Use address to which admission permit and other notification from ECFMG should be sent
Number/Street:
Apartment Number:
Post Office Box Number: 1653
City: HYATTSVILLE
State/Country: MD
Zip or Postal Code: 20788

**④ U. S. SOCIAL SECURITY AND/OR CANADIAN SOCIAL INSURANCE NUMBERS:**
Enter numbers in boxes provided
U.S. Social Security Number:
Canadian Social Insurance Number:

**⑤ REGISTRATION:** Check ☑ box(es) of selected examinations

| | | | | |
|---|---|---|---|---|
| Step 1 | June 8 - 9, 1994 | ☐ | or | September 22 - 23, 1994 ☑ |
| Step 2 | March 30 - 31, 1994 | ☐ | or | August 31 - September 1, 1994 ☑ |
| ECFMG English Test | March 31, 1994 | ☐ | or | September 1, 1994 ☑ |

**5.1 TEST CENTER:** Select three ECFMG centers for each Step and/or ECFMG English Test. See the Information Booklet in which this application was enclosed for a list of ECFMG centers

If your center selections are not available, ECFMG reserves the right to assign a center.

Step 1: (1) Richmond (City) 182 (Center No.) (2) Baltimore (City) 300 (Center No.) (3) _____ (City) _____ (Center No.)

Step 2 and/or ECFMG English Test: (1) Richmond (City) 182 (Center No.) (2) Baltimore (City) 300 (Center No.) (3) _____ (City) _____ (Center No.)

**⑥ EXAMINATION FEE(S):** Enter the amount enclosed on the line provided

Fees must be paid in United States funds. Checks, bank drafts or money orders are to be made payable to the ECFMG. Do not send cash.

| | |
|---|---|
| Step 1 Basic Medical Science Examination | $400 |
| Step 2 Clinical Science Examination | $400 |
| ECFMG English Test | $ 30 |

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Enter amount enclosed $ _____

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**⑦ HANDEDNESS:** ☑ Right Handed ☐ Left Handed

APPLICATION FORM 104S, August, 1993



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EXHIBIT 4
Kelly
AD 8/20/19
PENGAD 800-631-6989

## PART B

**⑧ SECONDARY SCHOOL / COLLEGE / UNIVERSITY:**

| Schools Attended | Location (exact address) | Dates Attended From (MO. YR.) | Dates Attended To (MO. YR.) | No. School Years |
|---|---|---|---|---|
| Immaculate Conception College | Benin City Nigeria | 06 74 | 06 79 | 05 |

**⑨ MEDICAL SCHOOL:** Use precise name and list all schools attended 690-010

| Schools Attended | Location (exact address) | Dates Attended From (MO. YR.) | Dates Attended To (MO. YR.) | No. School Years |
|---|---|---|---|---|
| University of Ibadan | Ibadan Nigeria | 06 82 | 06 87 | 05 |

**⑨.1 CLINICAL CLERKSHIPS:** Refers to that period of medical education in the clinical disciplines during which as a medical student you gained practical experience in hospitals or clinics. List clerkships (rotations, pre-graduate internships) for each clinical discipline.

| Clinical Discipline | Hospital/Clinic | Location (exact address) | Supervising Physician | Dates of Clerkship |
|---|---|---|---|---|
| MEDICINE | SPECIALIST HOSP. BENIN CITY | | DR Onwuka | 1988 |
| SURGERY | ✓ | ✓ | DR Idiakhoa | 1988 |
| OBGYN | ✓ | ✓ | DR Iyabor | 1988 |
| PEDIATRICS | ✓ | ✓ | DR ASEMOTA | 1987 |

If additional lines are necessary use the reverse side of Part C.

**⑨.2 MEDICAL DEGREE:** Conferred or Expected

Title of Degree MBBS Date Conferred:/Expected:* 0687

* If the degree has been conferred, a photocopy should be sent to ECFMG. See *Medical Education Credentials* Section of the ECFMG Information Booklet.

**⑩ MEDICAL LICENSURE:** Present or Future

Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine: 1988 Country or state in which you are licensed:* NIGERIA

* If the license has been issued, a photocopy should be sent to ECFMG. See *Medical Education Credentials* Section of the ECFMG Information Booklet.

**⑪ HOSPITAL TRAINING:** Residency or fellowship

| Hospitals | Position(s) | Dates |
|---|---|---|
| N/A | | |

**⑫ EMPLOYMENT:** Present employment only

| Institution/Company | Position | Dates |
|---|---|---|
| Name: N/A | | |
| Street: | | |
| City/State/Country: | | |

**⑬ BIRTHDATE/BIRTHPLACE:** Day 17 Month 04 Year 61 Location: IFE OYO NIGERIA (City, Province, Country)

**⑭ GENDER:** Please check one: ✓ Male ___ Female

**⑮ NATIVE LANGUAGE:** YORUBA

**⑯ CITIZENSHIP:** (Complete all three)

A. AT BIRTH USA ☐ Other ☑ (Specify) NIGERIAN 056

B. UPON ENTERING MEDICAL SCHOOL USA ☐ Other ☑ (Specify) NIGERIAN

C. NOW USA ☐ Other ☑ (Specify) NIGERIAN

**⑰ OTHER EXAMINATION HISTORY AND APPLICANT NUMBERS:** Indicate the organizations to which you may have applied previously; enter the date of the most recent examination that was administered to you

| ORGANIZATION | DATE OF MOST RECENT EXAMINATION TAKEN (MO. YR.) | APPLICANT IDENTIFICATION NUMBER |
|---|---|---|
| ☐ NATIONAL BOARD OF MEDICAL EXAMINERS | | |
| ☐ STATE LICENSING AUTHORITY IN THE UNITED STATES | | |

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School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical

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recent examination that was administered to you by that organization as

☐ IN THE UNITED STATES

Students and graduates must sign the application in the presence of their Medical School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) *and* must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

**Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.**

**All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.**

Seal, stamp or signature of official *must cover a portion* of the attached photograph.

**(18) CERTIFICATION BY APPLICANT**

**(Must be completed in English)**

I hereby certify that the information in this application is true and accurate to the best of my knowledge and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition of the Information Booklet on USMLE Step 1 and Step 2 examinations and ECFMG Certification, am aware of its contents and meet the eligibility requirements set therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action.

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any Federal, State, or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

RECEIVED

MAR 30 1994

ECFMG

Signature of Applicant (In Latin Characters) x Charles Igberume Ihejeme Date 03/26/94

**(18.1) (Must be completed in English)**

**CERTIFICATION BY MEDICAL SCHOOL OFFICIAL**

**OR**

**NOTARIZATION WITH EXPLANATION (Pertains to graduates only)**

**A.** I hereby certify that the photograph, signature, and information entered on Section 9 of this form accurately apply to the individual named above.

x _____
Signature of Medical School Official

Official Title | Date | Institution

**B.** Subscribed and sworn to before me this 26th day of March, 19 94

x Jack L. Katz
Signature of Consular Official, First Class Magistrate, Notary Public

JACK L. KATZ
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires June 1, 1997
Official Title

**B.1** Explain in the space below why the application form could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

Due to the fact that I reside in the United States as at time of filling this application

| FOR OFFICE USE ONLY | |
|---|---|
| FORM | DATE |
| S.A. | |
| I.D. | |
| 338 | |
| 339 | ✓ |
| 325 | ✓ |
| | |

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**(19)** Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked? ☐ Yes ☐ No

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

**(20)** Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the info... however, the processing of your application will not be affected if you choose to leave item (20) blank.

Select the one which best describes your racial/ethnic background.

1 ☐ American Indian/Alaskan Native
2 ☐ Asian Pacific Islander
3 ☐ Hispanic
4 ☐ Black (not of Hispanic Origin)
5 ☐ White (not of Hispanic Origin)
6 ☐ Other

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